

Walter Reed Cardiovascular Center



A Monthly Newsletter of the Cardiology Division of Walter Reed Army Medical Center

Commentary

Marina Vernalis, DO FACC

Folate treatment to reduce homocysteine level and assessment of C-reactive protein level are practiced with varying degrees by primary care providers and cardiologists. Much still needs to be investigated but recent data are summarized below.

Please contact us by phone, pager or e-mail with any questions. We remain available for emergency and routine consults as well as the "quick case to run by you".

Finally, take a look at the "Images In Clinical Medicine" in the New England Journal, 26 June 2003, to see "Shot to the Heart" from our own Lance Sullenberger and MJ Rohrer.*

* N Engl J Med 2003;348:2634 www.nejm.org

Cardiovascular Update

Daniel E. Simpson, MD FACC

Secondary Prevention With Folic Acid

An elevated homocysteine level is a modest predictor of cardiovascular risk. Treatment with folic acid can effectively reduce homocysteine. However, it is unknown if this reduction modifies the cardiovascular risk in secondary prevention.

Liem et al randomized, in an open-label fashion, 593 patients with known stable CAD to 0.5 mg/day of folic acid or nothing. All patients received standard of care therapy with statins.

Mean follow-up time was 24 months. There was a significant 18% reduction in homocysteine level with folic acid (12.0 to 9.4 umol/L) but no change without therapy. However, there was no difference in the primary endpoint of all-cause mortality/any vascular event (10.3% with folic acid v 9.6% without).

They concluded that despite a reduction in homocysteine levels, 2 years of treatment with low dose folic acid on top of standard statin therapy does not reduce clinical events.

* J Am Coll Cardiol 2003;41:2105-13 www.acc.org

Guideline Review

Daniel E. Simpson, MD FACC

AHA/CDC Recommendations for CRP Testing*

Data continues to accumulate demonstrating that inflammation is involved in the pathogenesis and progression of atherosclerosis. High sensitivity C-reactive protein (hs-CRP) is an excellent marker of cardiovascular risk and enhances the predictive value of the Framingham Risk Score. How best to use it has been uncertain until the January publication of the AHA/CDC Scientific Statement on "Markers of Inflammation and Cardiovascular Disease" in Circulation. The high points of the recommendations are as follows:

- 1) Routine screening of the entire adult population is not appropriate
- 2) It is reasonable to measure hs-CRP in patients with an intermediate risk by standard risk factor assessment (10 year coronary heart disease risk of 10-20%)
- 3) Patients at high risk by standard risk factor assessment (> 20% over 10 years) or with established CAD likely have little to gain from a hs-CRP level (treatment should be intensive regardless of level)
- 4) Two hs-CRP levels should be obtained one month apart to obtain an average
- 5) Serial hs-CRP testing is not warranted to monitor treatment
- 6) Ensure your lab is utilizing the high sensitivity (hs) assay
- 7) Levels > 10 mg/L should alert the physician to assess for other signs of infection or inflammation
- 8) Relative Risk Categories of Average hs-CRP
 - Low < 1 mg/L
 - Average 1-3 mg/L
 - High > 3 mg/L

* Circulation. 2003;107:499-511 www.circulationaha.org

Cardiovascular Trials at WRAMC

CARDIASTAR

PFO closure device versus standard anti-coagulation therapy with coumadin in patients with an embolic TIA/CVA and no other etiology

Questions/Referrals: Please contact Daniel Simpson

OPTIMIZE-HF

Assessment of inpatients with CHF and/or LV dysfunction to determine if guideline treatment is appropriately implemented

Questions/Referrals: Please contact Stephen Welka